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FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00416 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00413

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 6 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SHELBY — Middle M — Last ARMACOST
4. DATE OF DEATH: Month Jan — Day 12 — Year 1962

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | Jan 4 1886 | 76 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Railroad Emp | Maryland | U.S.A. |

13. FATHER'S NAME: William H Armacost
14. MOTHER'S MAIDEN NAME: Ellen G Trouble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 212-01-2333A
17. INFORMANT — Address: Mrs Ulysses Ebaugh - Westminster, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Arteriosclerotic Cardio-Renal disease | |
| DUE TO (b) | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|---|---|---|---|---|---|
| | | | | | |

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T Marsh, M.D.
EXAMINER'S NAME (Type): JAMES T. MARSH
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Carroll
DATE SIGNED: 1/12/62

| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or country) | (State) |
|---|---|---|---|---|
| Burial | 1-13-1962 | Hampstead | Carroll Co | Md |

23. FUNERAL DIRECTOR — ADDRESS: Tipton-Eline, Hampstead Md

24a. REC'D BY REGISTRAR DATE: JAN 16 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any d... sary, please exec... the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

80417 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 011414

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is unavoidable, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A1SME SM 9/60

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lineboro
c. LENGTH OF STAY IN 1b: 2 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lineboro
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First STEVE Middle DUWAYNE Last BAILEY

4. DATE OF DEATH: Month January Day 11 Year 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Nov 11-1961

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months 2 Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nass Bailey

14. MOTHER'S MAIDEN NAME: Ella May Burleson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT Address: Nass Bailey Lineboro Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial Pneumonitis. — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Charles Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]

Address (Street, city, town, or county):

DATE SIGNED: 1/11/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-13-61

22c. NAME OF CEMETERY OR CREMATORY: Liberty Hill Cem.

22d. LOCATION (City, town, or country) (State): Spruce Pine N.C.

23. FUNERAL DIRECTOR: Tipton-Elvie ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR DATE: JAN 15 '62

24b. REGISTRAR'S SIGNATURE: Charles S. Kuns

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Item 20a Film 306
2-5-62 ams

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# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00418

## CERTIFICATE OF DEATH

M1415

**1. PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.4mos.9dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 19
d. STREET ADDRESS: Box 540, Wise Ave., Rt. 10
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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**3. NAME OF DECEASED** (Type or print): First: Amelia; Middle: ; Last: Borchers

**4. DATE OF DEATH**: Month: January; Day: 22; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: July 15, 1885

**9. AGE** (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House-keeper

**10b. KIND OF BUSINESS OR INDUSTRY**: -

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Henry Gendengahl

**14. MOTHER'S MAIDEN NAME**: Margaret Frank

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wer or dates of service): No

**16. SOCIAL SECURITY NO.**: -

**17. INFORMANT** Address: Springfield Hospital Records

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with senile brain disease with psychotic reaction.

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☒ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.): Pt. found lying on floor.

**20c. TIME OF INJURY** Hour: 8:30 a.m. ☒ — Month, Day, Year: 12-26-1961

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☒

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): Hospital

**20f.** (City or town): Sykesville — (County): Carroll — (State): Md.

**21. I certify** that (I) (this hospital) attended the deceased from 9-13-, 1960 to 1-22-, 1962 that (I) (we) last saw the deceased alive on 1-22- 1962, and that death occured at 4:10 pm, from the causes and on the date stated above.

**22a. SIGNATURE**: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: 1-22-62

**22c. PHYSICIAN'S NAME** (Type): Agustin del Campo, M.D.

**22d. ADDRESS**: Springfield State Hospital, Sykesville, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 1/25/62 | Oak Lawn Cemetery | Baltimore Maryland |

| 24 FUNERAL DIRECTOR'S SIGNATURE | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| John A. Moran | 3000 E. Balto. St. Balto. Md | DATE JAN 25 '62 | Arthur S. Kraus |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 contains instructions obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
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Dr. Marsh, Medical examiner — notified; released case.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00419

## CERTIFICATE OF DEATH

00416

**1. PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rt.2 near Winfield

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Towson 4, 03X-2
d. STREET ADDRESS: 400 Allegheny
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Florence Middle: Gertrude Last: Brown

**4. DATE OF DEATH**: Month: 1-15-62 Day: Year: 19

**5. SEX**: female

**6. COLOR OR RACE**: white

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 4-9-1888

**9. AGE** (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): seamstress

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: William Brown

**14. MOTHER'S MAIDEN NAME**: Sally Jones

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown): no (If yes give war or dates of service)

**16. SOCIAL SECURITY NO.**: 214-22-1101

**17. INFORMANT**: Lloyd M. Shipley, 9 Fairfield Dr. Address: Balto.28, Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Parkinsons disease — 10 yrs

DUE TO (c): Gen. Arteriosclerosis — 10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 350 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 10/7 19 61 to Jan 15 19 62 that (I) (we) last saw the deceased alive on Jan 15th 19 62 and that death occured 8:55 A.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Morrell N Mastin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): MORRELL N MASTIN

**22d. ADDRESS**: Sykesville Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 1-18-62

**23c. NAME OF CEMETERY OR CREMATORY**: Jessop Methodist

**23d. LOCATION** (City, town or county) (State): Sparks, Md.

**24 FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Brooks Funeral Service, Inc., Towson 4, Md.

**25a. REC'D BY REGISTRAR** DATE: JAN 17 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Norris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00420 Items 2 & 12 Film G305 1/29/62 iwk 001417

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached and retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville
   c. LENGTH OF STAY IN 1b: 20y.11m.25d.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland — b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Unknown ✓ OIX-2 unknown
   d. STREET ADDRESS: Unknown ✓
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Amedel — Middle: --------- — Last: Clementi

4. **DATE OF DEATH**: Month: 1 — Day: 18 — Year: 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-15-1889

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R. Laborer

10b. KIND OF BUSINESS OR INDUSTRY: R.---R.

11. BIRTHPLACE (County & State, or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? Unknown ✓

13. FATHER'S NAME: Julius Clements?

14. MOTHER'S MAIDEN NAME: Anna----------(unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unknown (If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: 705-09-9010

17. INFORMANT — Address: Hospital Records

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia (right middle lobe) — INTERVAL BETWEEN ONSET AND DEATH: days

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Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Emphysema — years

DUE TO (c): Cardiac Decompensation — weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with cerebral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY: Hour ---- a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at Work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----

20f. (City or town) (County) (State): ---

21. **I certify** that (I) (this hospital) attended the deceased from September, 1961, to January 18 1962 that (I) (we) last saw the deceased alive on January 18 19 62, and that death occured at 1:50 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Yasuo Takahashi M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 1-18-62

22c. PHYSICIAN'S NAME (Type): Yasuo Takahashi, M.D.

22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1-22-62 — 23c. NAME OF CEMETERY OR CREMATORY: New Cathedral — 23d. LOCATION (City, town or county) (State): Baltimore, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Lutto A. Haight — ADDRESS: Sykesville, Md

25a. REC'D BY REGISTRAR DATE JAN 23 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A15 (4) 15M 7/61

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# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00421 00418

**1. PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 14
d. STREET ADDRESS: 5008 Grindon Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or Print): First: Ernest — Middle: Evert — Last: Cline

**4. DATE OF DEATH**: Month: January — Day: 24 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 1, 1887

9. AGE (In years last birthday): 74 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Asa Cline

14. MOTHER'S MAIDEN NAME: Jemima Heishman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes Cavalry 1910-1920

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Arteriosclerotic C.V.D. | years |
| DUE TO (b) | Generalized arteriosclerosis | years |
| DUE TO (c) | Moderately advanced pulmonary tuberculosis | years |
| | Calculus of the kidney | years |

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with cerebral arteriosclerosis without qualifying phrase

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OC - I

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-11-, 19 62 to 1-24-, 1962, that (I) (we) last saw the deceased alive on 1-24- 1962, and that death occured at 7..aM, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-24-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): [illegible]

23b. DATE THEREOF: 1-26-62

23c. NAME OF CEMETERY OR CREMATORY: Balto. National Cemetery

23d. LOCATION (City, town or county) (State): Balto. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: [illegible] Homeland Ave. Balto. 14

25a. REC'D BY REGISTRAR DATE: JAN 29 '62

25b. REGISTRAR'S SIGNATURE: Elmer L. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00422

## CERTIFICATE OF DEATH

00419

**1. PLACE OF DEATH**
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3 yrs. 10 dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1509 Northbourne
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Gertrude; Middle: Mary; Last: Clisham

**4. DATE OF DEATH**: Month: January; Day: 12; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: December 3, 1899

**9. AGE** (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Baby sitter

**10b. KIND OF BUSINESS OR INDUSTRY**: -

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: William J. Clisham

**14. MOTHER'S MAIDEN NAME**: Mary E. Ford

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service): No

**16. SOCIAL SECURITY NO.**: -

**17. INFORMANT** Address: Springfield Hospital Records

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombo-infarctive pneumonia
DUE TO (b): Decompensatory heart failure
DUE TO (c): Chronic mitral rheumatoid valvulitis with deformity.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 1 week

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, catatonic type. Arteriosclerosis.

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURED** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

MEDICAL CERTIFICATION

**21. I certify** that (I) (this hospital) attended the deceased from 1-2- 1959 to 1-12- 1962, that (I) (we) last saw the deceased alive on 1-12- 1962, and that death occured at 12:10 a.m. from the causes and on the date stated above.

**22a. SIGNATURE**: Agustin del Campo M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22b. DATE SIGNED**: 1-12-62
**22c. PHYSICIAN'S NAME** (Type): Agustin del Campo, M.D.
**22d. ADDRESS**: Springfield State Hospital, Sykesville, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL
**23b. DATE THEREOF**: 1/15/62
**23c. NAME OF CEMETERY OR CREMATORY**: New CATHEDRAL
**23d. LOCATION** (City, town or county) (State): BALTIMORE Md.

**24 FUNERAL DIRECTOR'S SIGNATURE**: L J. Ruck
ADDRESS: 5305 HARFORD Rd.

**25a. REC'D BY REGISTRAR** DATE: JAN 17 '62
**25b. REGISTRAR'S SIGNATURE**: Arthur L. Kruse

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 contained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S 4)
15M 7 61

1

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00423 — 00426

1. PLACE OF DEATH
a. COUNTY: Carroll — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — c. LENGTH OF STAY IN MARYLAND: 2 Mos. — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sykesville

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — d. STREET ADDRESS: Sykesville — e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ROY — Middle C. — Last CONAWAY

4. DATE OF DEATH: Month JAN. — Day 7, — Year 1962

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARR'ED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] — 8. DATE OF BIRTH: April 25, 1891 — 9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer ( Retired ) — 10b. KIND OF BUSINESS OR INDUSTRY: Farming — 11. BIRTHPLACE (County & state, or foreign country): Maryland — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Columbus A. Conaway — 14. MOTHER'S MAIDEN NAME: Ida B. Pickett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) — 16. SOCIAL SECURITY NO. 214-28-5352 — 17. INFORMANT: Mr. Gordon A. Conaway, Same as # 2 — Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Progressive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b): Chronic Hypertension — 5 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work [ ] Not While at work [ ] — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 7., 1962 to Dec 24, 1961, that (I) (we) last saw the deceased alive on Dec 20 1961, and that death occured at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Howell F Martin, M.D. — 22b. DATE SIGNED — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. PHYSICIAN'S NAME (Type): HOWELL F MARTIN — 22d. ADDRESS: Sykesville Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1-10-1962 — 23c. NAME OF CEMETERY OR CREMATORY: Morgan Chapel Cemetery — 23d. LOCATION (City, town or county) Carroll Co., (State) Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, — ADDRESS: Winfield, Maryland — 25a. REC'D BY REGISTRAR DATE JAN 10 '62 — 25b. REGISTRAR'S SIGNATURE: Carlton S. Evans

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00424 — 111421

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 contains instructions obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, deliver to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Winfield
c. LENGTH OF STAY IN MARYLAND: 6 Mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R. D. 2, Sykesville

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Winfield
d. STREET ADDRESS: R. D. 2, Sykesville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: VIRGINIA Last: CROOKS

4. DATE OF DEATH: Month: January Day: 5, Year: 1962

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 11, 1875

9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Lewis Dorsey

14. MOTHER'S MAIDEN NAME: Mary L. Hobbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Muriel Morrison, Same as # 2 — Address:

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac failure, Coronary thrombosis, — INTERVAL BETWEEN ONSET AND DEATH: 1960

DUE TO (b): Arteriosclerotic heart Disease, Arteriosclerosis — to

DUE TO (c): Generalized, Severe hypertension, anemia — 1962

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1962, 19..., to 1962, 19..., that (I) (we) last saw the deceased alive on 5 Jan 1962, and that death occured 11 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6 Jan 62

22c. PHYSICIAN'S NAME (Type): Howard E. Hall, M. D.

22d. ADDRESS: Sykesville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: jan.8, 1962

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cemetery

23d. LOCATION (City, town or county) (State): Randallstown, Marland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 9 '62

25b. REGISTRAR'S SIGNATURE: Esther L. Kraus

VR A15 4) 15M 7'61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00425

## CERTIFICATE OF DEATH

111422

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 to be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN MARYLAND: 1month,11days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution; Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodsboro
d. STREET ADDRESS: -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: Emory; Last: Crum

4. DATE OF DEATH: Month: January; Day: 4; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 23, 1881

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dairy farmer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Crum

14. MOTHER'S MAIDEN NAME: Nancy Dronberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records
Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia.
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: C.B.S. associated with cerebral arteriosclerosis without qualifying phrase.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.

20d. INJURY OCCURRED: Month, Day, Year 19 — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from November 23, 1961 to January 4, 1962, that (I) (we) last saw the deceased alive on January 4, 1962, and that death occured 11:55 AM from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1/4/62

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/8/62
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Mt. Hope
23d. LOCATION (City, town or county): Woodsboro (State): md.

24. FUNERAL DIRECTOR'S SIGNATURE: Y. C. Barton
ADDRESS: Walkersville, md.

25a. REC'D BY REGISTRAR: DATE JAN 8 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kuhns

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00426

## CERTIFICATE OF DEATH

00423

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 contained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S '41
15M 7 61

1 PLACE OF DEATH
a. COUNTY: ~~Allegany~~ Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN MARYLAND: 1yr.2mos.24dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 319 Cumberland Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Madalen; Middle: Agnes; Last: Dahl

4. DATE OF DEATH: January 14 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 29, 1897

9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Beauty Salon Operator

10b. KIND OF BUSINESS OR INDUSTRY: - Own

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles J. Dahl

14. MOTHER'S MAIDEN NAME: Mary Josephine Rohman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Springfield Hospital Records
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebral thrombosis | days |
| DUE TO (b) | Cerebral arteriosclerosis | years |
| DUE TO (c) | Generalized arteriosclerosis | years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. of unknown or unspecified cause with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY: Hour a.m. p.m. / Month / Day / Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10-20-, 1960 to 1-14-, 1962, that (I) (we) last saw the deceased alive on 1-14-1962, and that death occured at 11:45 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-14-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 18, 1962

23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem.

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: JAN 18 '62

25b. REGISTRAR'S SIGNATURE: Curtis L. Thomas

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 0427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 011424

1. PLACE OF DEATH
a. COUNTY: CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN: MARYLAND YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MAIN ST.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
d. STREET ADDRESS: MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SAVILLA Middle VIOLA Last DEVILBISS

4. DATE OF DEATH: Month JAN Day 17 Year 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 24 1898

9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): ILLNOISE

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: EDWARD RITTER

14. MOTHER'S MAIDEN NAME: RUTH LAWTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-09-0050

17. INFORMANT Address: HARRY DEVILBISS UNION BRIDGE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Strangulation by hanging — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Carroll

DATE SIGNED: 1-17-62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1/20/62

22c. NAME OF CEMETERY OR CREMATORY: KEYSVILLE

22d. LOCATION (City, town, or country): KEYSVILLE (State): MD

23. FUNERAL DIRECTOR ADDRESS: D.D. Hartzler & Sons Union Bridge

24a. REC'D BY REGISTRAR DATE: N 22 '62

24b. REGISTRAR'S SIGNATURE: Clifton S. Kuns

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay [illegible], please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be destroyed for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 111425

1 PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR
c. LENGTH OF STAY IN 1b YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW WINDSOR
d. STREET ADDRESS RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: LETSIE Middle: R. Last: DORSEY

4. DATE OF DEATH Month: JAN Day: 19 Year: 1962

5. SEX: FEMALE
6. COLOR OR RACE: COLORED
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 2-1895
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: HANFORD JONES
14. MOTHER'S MAIDEN NAME: NETTIE MURDOCK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: NONE
INFORMANT: JAMES A. SUMMERS Address: NEW WINDSOR MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b) Cirrhosis of liver — 5+ yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 14, 1962 to Jan 19, 1962 that I last saw the deceased alive on Jan 17, 1962 and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C Reese Wilkens M.D. ADDRESS (Street, city or town, state): 15 Kemper Ave Hanover Pa DATE SIGNED: 1-23-62
PHYSICIAN'S NAME (Type): DR. C Reese Wilkens

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JAN 23-62
22c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEM.
22d. LOCATION (City, town, or county) (State): TAYLORSVILLE MD.

23. FUNERAL DIRECTOR'S SIGNATURE: D.O. Hartlebaugh ADDRESS: New Windsor Md
24a. REC'D BY REGISTRAR DATE: JAN 23 '62
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00429 001425

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville
c. LENGTH OF STAY IN THIS PLACE 25 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sykesville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CARL Middle H Last EDEN

4. DATE OF DEATH Month Jan. Day 13 Year 1962

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 17, 1902
9. AGE (In years last birthday) 59 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Manager
10b. KIND OF BUSINESS OR INDUSTRY Spun Fully Nylon Fiber
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry D. Edel
14. MOTHER'S MAIDEN NAME Dora Küchmüller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Ethel Edel Address Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMBOLISM OF CORONARY ARTERY — INTERVAL BETWEEN ONSET AND DEATH 3 hrs.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~the hospital~~) attended the deceased from 1940, 19__ to Jan. 13, 19 62 that (I) (we) last saw the deceased alive on Jan. 13 19 62 and that death occurred at 2:00 pm, from the causes and on the date stated above.

22a. SIGNATURE Wm. H. Lawson, Jr. M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 1.13.62
22c. PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D.
22d. ADDRESS Sykesville-2, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 1-16-62
23c. NAME OF CEMETERY OR CREMATORY Houdon Park
23d. LOCATION (City, town, or county) (State) Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight ADDRESS Sykesville Md.
25a. REC'D BY REGISTRAR DATE JAN 22 '62
25b. REGISTRAR'S SIGNATURE T. S. Timms

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** Only this certificate has been signed by the attending physician and completely filled in by the informant. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00430 — 001427

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 16 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Baltimore City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 3700 Frankford Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HEDWIG — Middle: J. — Last: EISENMEIER

4. DATE OF DEATH: Month: 1 — Day: 7 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5-12-1889

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dressmaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Koessel

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Records, Springfield State Hospital

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Pyelonephritis, purulent.

DUE TO (b): Nephrolithiasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic cardiovascular disease.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.: Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December 21, 1961 to January 7, 1962, that (I) (we) last saw the deceased alive on January 7 1962, and that death occured at 1:50 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward F. Kerman M.D.

22b. DATE SIGNED: 1-8-62

22c. PHYSICIAN'S NAME (Type): Edward F. Kerman, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/10/62

23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

23d. LOCATION (City, town or county) (State): Balto Md

24. FUNERAL DIRECTOR'S SIGNATURE: C. F. Evans & Son — ADDRESS: 8802 Harford Rd.

25a. REC'D BY REGISTRAR — DATE: JAN 10 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

90431 — 00424

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
   c. LENGTH OF STAY IN 1b: 24 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington Co. ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: 232 N. Potomac St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Walter — Middle: — Last: FELDMAN

4. **DATE OF DEATH**: Month: January — Day: 27, — Year: 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/28/1885

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping clerk

10b. KIND OF BUSINESS OR INDUSTRY: Electrical

11. BIRTHPLACE (County & State, or country): Maryland - Wash. Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles A. Feldman

14. MOTHER'S MAIDEN NAME: Elizabeth A. Schaubla

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-09-3916

17. INFORMANT: Springfield State Hosp., Sykesville, Md. — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: days

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c): A.S.C.V.D. — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS assoc. with arteriosclerosis with psychosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County, — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/3/62 19 to 1/27/62 19 .., that (I) (we) last saw the deceased alive on 1/27/62 19 , and that death occured at 8:20 a.m. M, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

22b. DATE SIGNED: 1/27/62

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-30-62

23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery

23d. LOCATION (City, town or county) (State): Hagerstown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Scott F. Minnich & Son Hagerstown, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 30 '62

25b. REGISTRAR'S SIGNATURE: Clarence L. Nuna

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00432

## CERTIFICATE OF DEATH

11429

1

M

I

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Co. General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institutional: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-- Gamber
d. STREET ADDRESS: R. D. 1, Finksburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HENRY Middle TODD Last Ford

4. DATE OF DEATH: Month January Day 25, Year 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 22, 1895

9. AGE (In years last birthday): 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gen. Foreman (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Congoleum

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Buchannon Ford

14. MOTHER'S MAIDEN NAME: Virginia Eberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) yes (If yes give war or dates of service):

16. SOCIAL SECURITY NO: W. W. One 216-07-4170

17. INFORMANT: Mrs. Evelyn A. Ford, Same as # 2 — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Central hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Hypertension
DUE TO (c): Chr bronchitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 31 Hyp. - 19 .., to 1-25- ..., 1962 that (I) (we) last saw the deceased alive on 1-25- 1962 and that death occured at 6:21 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm. C. Jennette Jr. M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Wm. C. JENNETTE, M.D.

22d. ADDRESS: 103 E MAIN WESTMINSTER Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan-27, 1962

23c. NAME OF CEMETERY OR CREMATORY: Providence Cemetery

23d LOCATION (City, town or county) (State): Carroll Co., Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 29 '62

25b. REGISTRAR'S SIGNATURE: Esther E. Keener

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 explained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 111430

~~Item 9 film 6307~~ 1/24/62 lwk

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6yrs9mos18dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
d. STREET ADDRESS: 322 6th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Nelson; Last: France

4. DATE OF DEATH: Month: January; Day: 16; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 11, 1895

9. AGE (In years last birthday): 66 67 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel N. France

14. MOTHER'S MAIDEN NAME: Leonora Linnegan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service): -

16. SOCIAL SECURITY NO.: 213-05-7786

17. INFORMANT Address: Springfield Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Acute congestive heart failure | Minutes |
| DUE TO (b) | Arteriosclerotic cardiovalvular disease | Years |
| DUE TO (c) | Generalized arteriosclerosis, severe | Years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): James T. Marsh, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 1-16-62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JAN. 20, 1962

22c. NAME OF CEMETERY OR CREMATORY: WOODLAWN

22d. LOCATION (City, town, or country) (State): BALTIMORE, MD.

23. FUNERAL DIRECTOR: Paul E. Chaconas Jr. ADDRESS: 361 Chatsworth Ave

24a. REC'D BY REGISTRAR DATE: JAN 29 '62

24b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is expected, please execute, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

DD434 — Reg. Dist. No. 111431

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md — b. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster — c. LENGTH OF STAY IN 1b: 4 yrs
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Westminster
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
d. STREET ADDRESS: # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Ira — Middle: B. — Last: Garrick
4. DATE OF DEATH: Month: Jan — Day: 28 — Year: 1962
5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 10/8/1879 — 9. AGE (In years last birthday): 82 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Farmer 5 yrs — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country): Carroll Co Md — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peer Garrick — 14. MOTHER'S MAIDEN NAME: Priscilla B. Stanger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: None — INFORMANT (Address): Mrs Ira Garrick Westminster Md #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

(a) IMMEDIATE CAUSE: Myocardial — 1 yr

DUE TO

(b) hypertensive cardio-vascular disease — 6 yrs

DUE TO

(c) disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): decubitus ulcer of back - 2 months — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year, Hour, a m, p. m — 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 26 March, 19 56, to 28 January, 1962 that I last saw the deceased alive on 22 January, 1962, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A.G. Tananis M.D. — M.D. — ADDRESS (Street, city or town, state): 343 North St — DATE SIGNED: 1/29/62

PHYSICIAN'S NAME (Type): A.A. TANANIS M.D. — McSherrystown Pa

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF 1/31/62 — 22c. NAME OF CEMETERY OR CREMATORY Black Rock — 22d. LOCATION (City, town, or county) (State) Black Rock Md Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Frederick Bucher Hanover Pa — ADDRESS

24a. REC'D BY REGISTRAR DATE JAN 31 '62 — 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00435 — 111432

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) ISM 7/61

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 2
d. STREET ADDRESS: 1117 E. North Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jack — Middle: — Last: Haddock

4. DATE OF DEATH: Month: January — Day: 17, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 1, 1886

9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Storekeeper

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edwin Haddock

14. MOTHER'S MAIDEN NAME: Sarah Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: - -

17. INFORMANT: Mrs. Iola M. Haddock — Address: 1117 E. North Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 - 3 days
DUE TO (b): Arteriosclerotic cardiovascular disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1a: C.B.S., cerebral arteriosclerosis with psychosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from January 5, 1962 to January 17, 1962 that (I) (we) last saw the deceased alive on January 17, 1962, and that death occured at 3:20 PM from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1/17/62

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-22-62

23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Wm J. Lichtenstein — ADDRESS: 1117 Pa Balto 17

25a. REC'D BY REGISTRAR DATE: JAN 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur J. Hamm

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00436 — Reg. Dist. No. 11433

1 PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 5 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 108 E. MAIN ST.

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 108 E. MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JAMES — Middle ELMER — Last HAISLIP

4. DATE OF DEATH: Month JANUARY — Day 14 — Year 1962

5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JULY 31 1887
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MOTORMAN - TRANSIT - TRANSPORTATION
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: ALEXANDRIA HAISLIP
14. MOTHER'S MAIDEN NAME: JOSEPHINE WILLIAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-03-4074
INFORMANT: MRS. PAULINE HISLIP (WIFE)
Address: 108 E. MAIN ST. WESTMINSTER MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): BRONCHOGENIC CARCINOMA LUNG — INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a m. p m — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT, 1959, to JANUARY, 1962 that I last saw the deceased alive on JANUARY 14, 1962, and that death occurred at 12 45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel P Welliver M.D.
ADDRESS (Street, city or town, state): 19 RIDGE ROAD
DATE SIGNED: 1/14/62
PHYSICIAN'S NAME (Type): DAMEL I. WELLIVER WESTMINSTER MARYLAND

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Jan. 17, 62
22c. NAME OF CEMETERY OR CREMATORY: Burnt Church Cemetery
22d LOCATION (City, town, or county) (State): Rural Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. E. Myers, Jr. Westminster, Md
24a. REC'D BY REGISTRAR DATE: JAN 16 '62
24b REGISTRAR'S SIGNATURE: Evelyn L. Nims

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

60437 — 111434

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Middleburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brookfield Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pro George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park, Md.
d. STREET ADDRESS: 7002 Dartmouth Avenue,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: M. — Last: Hanneford

4. DATE OF DEATH: Month: Jan — Day: 21 — Year: 1962

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: July 9, 1878
9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Maine
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Scanlin
14. MOTHER'S MAIDEN NAME: Priscilla Smith Berwyn Heights Md

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Rena Brewrink — Address: Berwyn Heights Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year: Hour o. m. / p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/29/61 19___ to 1/21/62 19___, that (I) (we) last saw the deceased alive on 1/21/62 19___, and that death occurred at 4:20 PM, from the causes and on the date stated above.

22a. SIGNATURE: J. H. Caricofe M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 1/21/62
22c. PHYSICIAN'S NAME [Type]: J. H. CARICOFE M D.
22d. ADDRESS: 118 S. Main St. Union Bridge Md

23a. BURIAL CREMATION, REMOVAL (Specify): Transportation
23b. DATE THEREOF: 1/23/62
23c. NAME OF CEMETERY OR CREMATORY: Bangor
23d. LOCATION (City, town, or county) (State): Maine

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Md.
25a. REC'D BY REGISTRAR DATE: JAN 25 '62
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR A[illegible] PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained [illegible]al or attending physician.
TO FUNERAL DIRE[illegible] this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00438 — Items 8 & 9 Film G305 1/18/62 — 111435

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH — a. COUNTY: Carroll — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — MARYLAND — c. LENGTH OF STAY IN 1b: 4 Months

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Golden Age Guest Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Md — b. COUNTY: Anne Arundel — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie — STREET ADDRESS: #307 Walton Ave — RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or Print): First: Miranda — Middle: Earl — Last: Harwood

4. DATE OF DEATH: Month: Jan — Day: 9th — Year: 1962

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar 8 1886 — 9. AGE (In years) If UNDER 1 YEAR last birthday: Months, Days — IF UNDER 24 HRS.: Hours, Min. — 75 — 9 12

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Supervisor (Ret.) — 10b. KIND OF BUSINESS OR INDUSTRY:

11. PLACE OF BIRTH (City or Town, State or foreign country): Baltimore Md — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gregg Harwood — 14. MOTHER'S MAIDEN NAME: Martha Harvey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: 220-09-2773 — 17. INFORMANT: John Collins — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 332 X — DUE TO (b): Cerebral Embolism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c): Gen. Arter. Sclerosis ?
Parkinson Syndrome 10 yr

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov 12, 19 61 to Jan 9, 19 62, that (I) (we) last saw the deceased alive on Jan 8, 19 62, and that death occured at 12:45 pm from the causes and on the date stated above.

22a. SIGNATURE: Morell N Martin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 1/9/62

22c. PHYSICIAN'S NAME (Type): MORRELL N MARTIN — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1/12/62 — 23c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery — 23d. LOCATION (City, town or county) (State): Baltimore, Md

24. FUNERAL DIRECTOR'S SIGNATURE: J Kirkley — ADDRESS: Hopping & Kirkley, Glen Burnie, Md — 25a. REC'D BY REGISTRAR DATE: JAN 15 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur E. Hinkle

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00439 — 001436

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 8 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 24
d. STREET ADDRESS: 914 S. Bouldin St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: Helgert

4. DATE OF DEATH: Month: January — Day: 21, — Year: 19 62

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: June 12, 1877 — 9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sebastian Helgert
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO: 212-03-3721
17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterial occlusion plus shock
DUE TO (b): Arteriosclerotic cardiovascular disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

INTERVAL BETWEEN ONSET AND DEATH: Days / Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: C.B.S. with cerebral arteriosclerosis without qualifying phrase.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 22, ....., 1961 to January 21, 1962, that (I) (we) last saw the deceased alive on January 21, 19..62, and that death occured at 10:40PM from the causes and on the date stated above

22a. SIGNATURE: Agustin del Campo M.D.
22b. DATE SIGNED: 1/22/62
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-25-62.
23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
23d. LOCATION (City, town or county) (State): 4430 Belair Rd. Balto. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles S. Zeiler
ADDRESS: 901 S. Conkling St. Balto., 24, Md.

25a. REC'D BY REGISTRAR DATE: JAN 26 '62
25b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00440 — 00437

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

**1. PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 15 days / 5 yrs./2 mths.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore #18
d. STREET ADDRESS: 930 Montpelier St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: William — Middle: — Last: HESS

**4. DATE OF DEATH**: Month: Jan. — Day: 21, — Year: 1962

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 12-18-94

**9. AGE** (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Newspaper Salesman

**10b. KIND OF BUSINESS OR INDUSTRY**: —

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Fred Hess

**14. MOTHER'S MAIDEN NAME**: Katherine Kraffa

**15. WAS DECEASED EVER IN U S ARMED FORCES?** (Yes, no, or unkown): no — (If yes give war or dates of service): —

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT** — Address: Springfield Hospital Records; Sykesville, Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Involutional psychotic reaction.

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

MEDICAL CERTIFICATION

**21. I certify** that (I) (this hospital) attended the deceased from 11/6/56, 19..., to 1/21/62, 19..., that (I) (we) last saw the deceased alive on 1/21/62 19..., and that death occured at 9 a M, from the causes and on the date stated above.

**22a. SIGNATURE**: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

**22b. DATE SIGNED**: 1/21/62

**22c. PHYS CIAN'S NAME** (Type): Agustin del Campo, M.D.

**22d. ADDRESS**: Sykesville, Maryland

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF**: 1-24-62

**23c. NAME OF CEMETERY OR CREMATORY**: Baltimore Cemetery

**23d. LOCATION** (City, town or county): Baltimore (State):

**24 FUNERAL DIRECTOR'S SIGNATURE** — ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

**25a. REC'D BY REGISTRAR** DATE JAN 24 '62

**25b REGISTRAR'S SIGNATURE**: Clifford L. Pierce

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00441 — 004438

1. **PLACE OF DEATH**
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 7yrs. 9days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Westminster
d. STREET ADDRESS: Route #5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Jessie; Middle: Blanche; Last: Hollinger

4. **DATE OF DEATH**: Month: January; Day: 26; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: September 18, 1875

9. AGE (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred Barnes

14. MOTHER'S MAIDEN NAME: Susan ? E. Barnes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records
Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)): [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Calcareous stenosis and insufficiency of aortic and mitral valve due to generalized arteriosclerosis.

DUE TO (c): Dehydration

INTERVAL BETWEEN ONSET AND DEATH: 10-20- years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with Disturbance of Metabolism, Growth or Nutrition with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-17-, 1955 to 1-26-, 1962, that (I) (we) last saw the deceased alive on 1-26- 1962, and that death occured at 8:30 a.m. p.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-26-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 28, 1962

23c. NAME OF CEMETERY OR CREMATORY: Stone Chapel Cemetery

23d. LOCATION (City, town or county) (State): Carroll Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: C. M. Waltz, Winfield, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 29 '62

25b. REGISTRAR'S SIGNATURE: [signature]

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 2[illegible] hours after death. Page 1 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00442

## CERTIFICATE OF DEATH

00439

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CHURCH ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
d. STREET ADDRESS: CHURCH ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE — Middle MAY — Last HOUGH

4. DATE OF DEATH: Month JAN. — Day 15 — Year 1962

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAR. 19 - 1881
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: GRAFTON B CLAY
14. MOTHER'S MAIDEN NAME: MARY STARR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: EDGAR C. HOUGH SR. — Address: NEW WINDSOR MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 4 Myocardial Silitation
DUE TO (b): 3 Chronic Myocarditis
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 11 1962, to Jan 15 1962, that (I) (we) last saw the deceased alive on Jan 11 1962 and that death occurred at 3:45 P.M. from the causes and on the date stated above

22a. SIGNATURE: T. H. Legg M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 1-15-62
22c. PHYSICIAN'S NAME (Type): T. H. LEGG, M.D.
22d. ADDRESS: Union Bridge Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN. 17-62
23c. NAME OF CEMETERY OR CREMATORY: FRIENDS CEMETERY
23d. LOCATION (City, town, or county) (State): UNION BRIDGE MD

24. FUNERAL DIRECTOR'S SIGNATURE: D. W. Hartlutions
ADDRESS: NEW WINDSOR MD.

25a. REC'D BY REGISTRAR DATE: JAN 18 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00443 — 1114311

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 1,072 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: Route #3, Box 334
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Lucinda — Last: Johnson

4. DATE OF DEATH: Month: Jan. — Day: 16, — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 5-3-1930

9. AGE (In years last birthday): 31 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Brogden

14. MOTHER'S MAIDEN NAME: Grace Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 214-28-8945

17. INFORMANT: Florence L. Johnson - Patient — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Far advanced bilateral cavitary pulmonary tbc.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 9, 1959 to Jan. 16, 1962, that (I) (we) last saw the deceased alive on Jan. 16, 19 62, and that death occured at 3:10 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Edgars M. Maculans, Supt. Henryton State Hosp., Henryton, Md.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b DATE THEREOF: 1/20/62

23c NAME OF CEMETERY OR CREMATORY: Mt. Pleasant.,

23d. LOCATION (City, town or county) (State): Norbeck, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Amoureux — ADDRESS: Rockville, Md.

25a. REC'D BY REGISTRAR DATE: JAN 24 62

25b. REGISTRAR'S SIGNATURE

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00444 Reg. Dist. No. 111441

1 PLACE OF DEATH
a. COUNTY: Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 68 Ralph Street

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 68 Ralph Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DAVID Middle FOWBLE Last JONES
4. DATE OF DEATH: Month JANUARY Day 3 Year 1962

5 SEX: MALE
6 COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: DEC. 21, 1876
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Thomas S. Jones
14 MOTHER'S MAIDEN NAME: Angeline Sellers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 216-24-9879
INFORMANT: Mrs. Elsie C. Jones, Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA OF COLON — INTERVAL BETWEEN ONSET AND DEATH: 6 MONTHS
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT. 19, 1959, to JAN. 3, 1962, that I last saw the deceased alive on JAN. 2, 1962, and that death occurred at 8:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William L. Stewart, M.D.
ADDRESS (Street, city or town, state): 19 RIDGE RD.
DATE SIGNED: 1/3/62
PHYSICIAN'S NAME (Type): William L. Stewart, M. D. WESTMINSTER, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 1-6-1962
22c. NAME OF CEMETERY OR CREMATORY: Pipe Creek Cemetery
22d LOCATION (City, town, or county) (State): Carroll Co., Maryland

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Maryland
24a. REC'D BY REGISTRAR DATE: JAN 5 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00445 — 011442

**1. PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 2y. 9m. 16d.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 4218 Lasalle Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Clara — Middle: Mary — Last: Keene

**4. DATE OF DEATH**: Month: 1 — Day: 9 — Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 6/28/87

**9. AGE** (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: George Campbell

**14. MOTHER'S MAIDEN NAME**: ~~Bowers~~ Mary Bauer

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wer or dates of service): no

**16. SOCIAL SECURITY NO.**: unknown

**17. INFORMANT** Address: Springfield Hospital records - Sykesville, Md.

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b): —
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Chronic brain syndrome associated with senile brain disease with psychotic reaction.

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that ☒ (this hospital) attended the deceased from 3/23/ 1959 to 1/9/ 1962 that ☒ (we) last saw the deceased alive on 1/9/ 1962, and that death occured at 7:35 AM, from the causes and on the date stated above.

**22a. SIGNATURE**: Naci N. Buyukunsal M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
**22b. DATE SIGNED**: 1/9/62

**22c. PHYSICIAN'S NAME** (Type): Naci N. Buyukunsal, M. D.

**22d. ADDRESS**: Springfield State Hospital, Sykesville, Maryland.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): burial
**23b. DATE THEREOF**: 1-12-62
**23c. NAME OF CEMETERY OR CREMATORY**: Holy Redeemer Cemetery Baltimore, Md.
**23d. LOCATION** (City, town or county) (State)

**24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: Leonard J. Ruck 5305 Harford Road

**25a. RECD BY REGISTRAR DATE**: JAN 11 '62
**25b. REGISTRAR'S SIGNATURE**: Clifton S Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00443

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA CARROLL CO. GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TANEYTOWN RURAL
d. STREET ADDRESS: MT UNION
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Vola — Middle: Kate — Last: KING

4. DATE OF DEATH: Month: JAN — Day: 16 — Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: JULY 26-1896

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN ROSENBAUM

14. MOTHER'S MAIDEN NAME: LENORA WHEELER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: BENNIE KING — Address: TANEYTOWN MD RURAL

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): A.S.C.V. disease & hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Months / Yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]

Address (Street, city, town, or county): Comus

DATE SIGNED: 1/16/62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1/19/62

22c. NAME OF CEMETERY OR CREMATORY: LUTHERAN

22d. LOCATION (City, town, or country) (State): UNIONTOWN MD

23. FUNERAL DIRECTOR — ADDRESS: D W Hartzler & Sons, Union Bridge

24a. REC'D BY REGISTRAR DATE: JAN 22 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

C0447 — 111144

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Weitzel Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: 341 Round Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET; Middle; Last KNOP

4. DATE OF DEATH: Month January; Day 17; Year 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 19, 1872
9. AGE (In years last birthday): 89 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: ? Brehm
14. MOTHER'S MAIDEN NAME: ? ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mr. Carl A. Knop, Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac failure, Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 16 Yr
DUE TO (b): Cerebral thrombosis, C.V.A., L. sided hemiplegia — 2 Yr
DUE TO (c): Chronic Brain Syndrome - Senile — 16 Yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____ 19__ to ____ 19__ that (I) (we) last saw the deceased alive on 17 Jan 1962 and that death occurred at 2:17 P.M. from the causes and on the date stated above

22a. SIGNATURE: Howard E Hall M.D.
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Howard E. Hall, M. D.
22d. ADDRESS: Ellicott City, Md. 17 Jan. 62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-19-1962
23c. NAME OF CEMETERY: Lorraine Park
23d. LOCATION (City, town, or county) (State): Baltimore Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 19 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) ISM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00448 — 011445

**1. PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville (Rural)
c. LENGTH OF STAY IN 1b: 40 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville - (Rural)
d. STREET ADDRESS
IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First JAMES — Middle G — Last LEISTER

**4. DATE OF DEATH**: Month Jan — Day 24 — Year 1962

**5. SEX**: M

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Jan 25 - 1881

**9. AGE** (In years. If under 1 year, months, days. If under 24 hrs., hours, min.): 80 yrs.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired

**10b. KIND OF BUSINESS OR INDUSTRY**: Farmer

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: David Leister

**14. MOTHER'S MAIDEN NAME**: Anna Danner

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) If yes, give war or dates of service: No

**16. SOCIAL SECURITY NO**: No

**17. INFORMANT**: Mrs J R Stuckline, Hampstead Md — Address

**18. CAUSE OF DEATH** (Enter only one cause per line for [a], [b], and [c].)

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Thrombosis.
DUE TO (b): Arterio-Sclerotic Cardiovascular disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I,a.

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-19 19 59 to 1-24 19, that (I) (we) last saw the deceased alive on 1-24 19 and that death occured at P.M. from the causes and on the date stated above.

22a. SIGNATURE: H. C. Porterfield M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 1-27

22c. PHYSICIAN'S NAME (Type): H.C. Porterfield — 22d. ADDRESS: Hampstead Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1-27-62 — 23c. NAME OF CEMETERY OR CREMATORY: Leisters — 23d. LOCATION (City, town or county) (State): Linwell Rd Md

24. FUNERAL DIRECTOR'S SIGNATURE: Tipton-Elmo — ADDRESS: Hampstead Md

25a. REC'D BY REGISTRAR DATE: JAN 29 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Travers

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00449 — 00446

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7.61

M

I

1. **PLACE OF DEATH**
   a. COUNTY: Carroll
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
   c. LENGTH OF STAY IN 1b: MARYLAND 3 days / 22 yrs. / 8 mos.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
   d. STREET ADDRESS: 2021 N. Fulton Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carl — Middle: M. — Last: LEITZ

4. DATE OF DEATH: Month: January — Day: 27, — Year: 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-5-99

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never Worked

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Leitz

14. MOTHER'S MAIDEN NAME: Caroline Beck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Springfield State Hosp. Records

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Congestive Heart Failure | Sudden |
| DUE TO (b) | Myocardial Infarction | Days |
| DUE TO (c) | Coronary Arteriosclerosis And Thrombosis | Years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental Deficiency, Idiopathick Severe.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from 5/24/39 ....., 19 ., to 1/27/62. , 19 .., that (I) (we) last saw the deceased alive on 1/27/62 19 , and that death occured at 1 pM, from the causes and on the date stated above

22a. SIGNATURE: Agustin del Campo M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1/27/62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1-30-62

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery — 23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Wm J Tinkham & Son — ADDRESS: 2k Otterbein Ave

25a. REC'D BY REGISTRAR — DATE: JAN 31 '62

25b. REGISTRAR'S SIGNATURE: [illegible] S. Evans

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00450 **CERTIFICATE OF DEATH** 111447

Item 8 - File Dupl 1/29/62 iwk

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7 61

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1month18dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brunswick 1025-2
d. STREET ADDRESS: 25 A Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Bertha — Middle: Eversale — Last: Lewis

4. **DATE OF DEATH**: Month: January — Day: 12 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 22, 1871

9. AGE (In years last birthday): 90 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Eversale

14. MOTHER'S MAIDEN NAME: TEmple Musters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease. — Interval between onset and death: Years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Paget's Disease — Years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).

C.B.S. associated with senile brain disease, without qualifying phrase.

19. WAS A AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-24-19 61 to 1-12-1962 that (I) (we) last saw the deceased alive on 1-12-1962, and that death occured at 2 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

22b. DATE SIGNED: 1-12-62

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1-15-62 — 23c. NAME OF CEMETERY OR CREMATORY: Green Hill — 23d. LOCATION (City, town or county) (State): Martinsburg W Va

24. FUNERAL DIRECTOR'S SIGNATURE: Teets Funeral Home — ADDRESS: Brunswick Md

25a. REC'D BY REGISTRAR DATE: JAN 19 '62

25b. REGISTRAR'S SIGNATURE: Chas. S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00451 — 00145

**1. PLACE OF DEATH**
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN Md: 4y. 4 m. 4 d.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: Leiper Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| Carrie | May | Lewis | 1 | 3 | 1962 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | white | | May ? 1902 | 59 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | West Virginia | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Paul A. Mullan | Grady |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | 216-22-6594 | Springfield Hospital records - Sykesville, Md. |

**MEDICAL CERTIFICATION**

18 **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Sepsis due to inflammatory parotitis — INTERVAL BETWEEN ONSET AND DEATH: Days

DUE TO (b): Cardiac failure.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

CBS associated with diseases of unknown or uncertain cause, Huntington's Chorea, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|---|---|---|---|---|---|---|
| | | | | | | |

21 **I certify** that ☒ (this hospital) attended the deceased from 8/29/57 ..., 19..., to ...1/3/..., 1962, that ☐ (we) last saw the deceased alive on ...1/3/...1962..., and that death occured at 1:25 P.M. from the causes and on the date stated above

22a SIGNATURE: Naci D. Buyukunsal M.D.

22b DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c PHYSICIAN'S NAME (Type): Naci Buyukunsal, M.D.

22d ADDRESS: Springfield State Hospital Sykesville, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) | (State) |
|---|---|---|---|---|
| Burial | 1-6-62 | SS. Peter & Paul | Cumberland | Md. |

24 FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer — ADDRESS: Cumberland Md.

25a. REC'D BY REGISTRAR DATE: JAN 12 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 7X
15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00452 — 11149

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4)
15M 7 61

1. **PLACE OF DEATH**
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN MARYLAND: 5 mo. 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1715 E. 29th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Agnes — Middle: — — Last: Logue

4. **DATE OF DEATH**: Month: 1 — Day: 9 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/22/85

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John McEvoy

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Springfield Hospital records - Sykesville, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: week

491 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a): Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20e ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 7/27/ 19 61 to 1/9/ 19 62, that ☒ (we) last saw the deceased alive on 1/9/ 19 62, and that death occured at 2:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Naci B. Buyukunsal M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M. D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 1-13-62

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.

23d. LOCATION (City, town or county): Baltimore, Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Leonard J. Ruck 5305 Harford Rd.

25a. REC'D BY REGISTRAR — DATE JAN 11 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Thorne

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00453 — 004516

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2-should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15
15M / 61

**1. PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 17 days | 2 yrs. / 6 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City #1
d. STREET ADDRESS: 638 W. Fayette St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Bernard — Middle: — Last: LOSER

**4. DATE OF DEATH**: Month: January — Day: 27, — Year: 1962

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

**8. DATE OF BIRTH**: 4-1-01

**9. AGE** (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life even if retired): -Unknown

**10b. KIND OF BUSINESS OR INDUSTRY**: Unknown

**11. BIRTHPLACE** (County & State, or foreign country): Switzerland

**12. CITIZEN OF WHAT COUNTRY?**: Unknown

**13. FATHER'S NAME**: Unknown

**14. MOTHER'S MAIDEN NAME**: Unknown.

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service): Unk

**16. SOCIAL SECURITY NO.**: 135-18-2234.

**17. INFORMANT** Address: Springfield Hospital Records.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, right lower lobe — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO (b): Pleurisy — Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.P.S.assoc.with circulatory dist. with cerebral arteriosclerosis with psychotic reaction.

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**MEDICAL CERTIFICATION**

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 10, 1959, to January 27, 1962, that (I) (we) last saw the deceased alive on January 27, 1962, and that death occured at 7:30 PM from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1/28/62

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-1-62
23c. NAME OF CEMETERY OR CREMATORY: Freedom
23d. LOCATION (City, town or county) (State): Ellicott City, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Little H. Haught Sykesville, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 5 '62
25b. REGISTRAR'S SIGNATURE: Charles S. Runn

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00454 — 00454

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital, give street address): Carroll County General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster 27
d. STREET ADDRESS: 143 E. Green St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ADDIE — Middle: B. — Last: MANAHAN

4. DATE OF DEATH: Month: JAN. — Day: 4 — Year: 1962

5. SEX: female — 6. COLOR OR RACE: white — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Aug. 24 1871 — 9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPAT ON (Give k nd of work done during most of working life, even if retired): None — 10b. K ND OF BUS.NESS OR INDUSTRY — 11. BIRTHPLACE (County o State or for gn country): Warfieldsburg, Carroll Co. Md. U.S.A. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Levi Manahan — 14. MOTHER'S MAIDEN NAME: Eliza Jane Baile

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) — (If yes give wer or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Miss Maud E. Manahan — Address: Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular disease — yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Jan 1, 1962 to Jan 4, 1962, that (I) (~~saw~~) last saw the deceased alive on Jan 3, 1962, and that death occured at 4:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: James T Marsh — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): JAMES T MARSH — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1/6/62 — 23c. NAME OF CEMETERY OR CREMATORY: Stone Chapel Cemetery — 23d. LOCATION (City, town or county) (State): Rural, Westminster, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers, Jr. — ADDRESS: Westminster, Md. — 25a. REC'D BY REGISTRAR: DATE JAN 8 '62 — 25b. REGISTRAR'S SIGNATURE: Carlton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00455

## CERTIFICATE OF DEATH

011452

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barnesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ANNIE — Middle IRENE — Last MANION

4. DATE OF DEATH: Month 1 — Day 2 — Year 19 62

5 SEX: Female

6. COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-6-77

9 AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Kierman Manion

14. MOTHER'S MAIDEN NAME: Mary R. Riley

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO:

17 INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure

DUE TO (b) Arteriosclerotic cardiovascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from December 19 1961, to January 2, 1962 that (I) (we) last saw the deceased alive on January 2 1962, and that death occurred at 9:30 A.M. from the causes and on the date stated above

22a. SIGNATURE: Edward F. Kerman M.D.

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED

22c PHYSICIAN'S NAME (Type): Edward F. Kerman, M. D.

22d ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/4/62

23c NAME OF CEMETERY OR CREMATORY: St. Marys

23d LOCATION (City, town, or county): Barnesville (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Constance C. Hilton ADDRESS: Barnesville Md

25a. REC'D BY REGISTRAR DATE JAN 4 '62

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00456 **CERTIFICATE OF DEATH** 00453

**1. PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 month20days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 7400 Garland Ave.
d. STREET ADDRESS: ~~Kensington~~ Takoma Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| Bessie | Gurevich | McClure | January | 9 | 1962 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | June 28, 1900 | 61 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Grocery Store | Odessa Russia | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| - Jacob Gurevich | - Rose ?(unknown) |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No - | 578-01-3296 | Springfield Hospital Records |

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Aspiration pneumonia | 4-5 days |
| DUE TO (b) | Comatose status and tracheatomy | 3 weeks |
| DUE TO (c) | Encephalopathy associated with metastasis (carcinoma left breast) | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

C.B.S. associated with new growth, with intracranial neoplasm, without qualifying phrase (metastatic)

20a. ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year 19 | 20d. INJURY OCCURRED White at work ☐ Not White at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office b.dg., etc.) | 20f. (City or town) | County | (State) |
|---|---|---|---|---|---|---|
| | | | | | | |

21. **I certify** that (I) (this hospital) attended the deceased from 12-19- , 1961, to 1-9- , 1962, that (I) (we) last saw the deceased alive on 1-9- 1962, and that death occured at 10:55 p.m. from the causes and on the date stated above.

| 22a. SIGNATURE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☐ | STAFF PHYS. ☒ | 22b. DATE SIGNED |
|---|---|---|---|---|
| Agustin del Campo M.D. | | | | 1-9-62 |

| 22c. PHYSICIAN'S NAME (Type) | 22d. ADDRESS |
|---|---|
| Agustin del Campo, M.D. | Springfield State Hospital, Sykesville, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 1-15-62 | Arlington Cemetery | Arlington, Virginia |

| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| P.A. Ziska 8434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md. | JAN 17 62 | Esther L. Mann |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

0457 — 01454

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 18yrs.6mos.11days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1006 Warden Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Paul; Middle: ; Last: Micriotti

4. DATE OF DEATH: Month: January; Day: 11; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December, 1874

9. AGE (In years last birthday): 87 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: ~~Angelo Micriotti~~ Francesca Miriscioli

14. MOTHER'S MAIDEN NAME: ~~[redacted] Micriotti~~ Angela Miriscioli
Address:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO: -

17. INFORMANT: Springfield Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | Arteriosclerotic heart disease | Years |
| DUE TO (b) | Generalized arteriosclerosis | Years |
| DUE TO (c) | | |

420.6

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a): C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction. Bronchopneumonia.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town, (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 30, ..... 19 43 to January 11, 1962, that (I) (we) last saw the deceased alive on January 11, 19 62, and that death occured at 10:08AM from the causes and on the date stated above

22a. SIGNATURE: Agustin del Campo. M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1/11/62

22c. PHYSICIAN'S NAME (Type): Agustin delCampo M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/15/62

23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Schimunek

ADDRESS: Funeral Home 3331 Brehms Lane

25a. REC'D BY REGISTRAR DATE: JAN 15 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7 61

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00458 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00455

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is ne[illegible]y, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral [illegible]or. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for [illegible] files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE RURAL
c. LENGTH OF STAY IN 1b: 5 Mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE RURAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GARFIELD Middle ANTHONY Last MILBERRY

4. DATE OF DEATH: Month JAN Day 15 Year 1962

5. SEX: M

6. COLOR OR RACE: COL

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG 12 - 1961

9. AGE (In years last birthday): yrs 5 | IF UNDER 1 YEAR: Months 5 Days 3 | IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: SARAH J MILBERRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: SARAH MILBERRY Address: UNION BRIDGE RURAL MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 15 Day

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I, or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James T Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Carroll

DATE SIGNED: 1/15/62

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1/17/62

22c. NAME OF CEMETERY OR CREMATORY: MT OLIVE

22d. LOCATION (City, town, or country) (State): FREDERICK Co MD

23. FUNERAL DIRECTOR: D D Hartzler & Sons ADDRESS: New Windsor, Md

24a. REC'D BY REGISTRAR DATE: JAN 18 '62

24b. REGISTRAR'S SIGNATURE: [signature]

203222 3V4

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00459

## CERTIFICATE OF DEATH

00456

**TO HOSPITAL OR FUNERAL DIRECTOR:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: CARROLL CO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - WESTMINSTER
c. LENGTH OF STAY IN 1b: 1 WK
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): OLD BALTIMORE BLVD.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL RT #2 SILVER RUN, MD.
d. STREET ADDRESS: CHERRYTOWN ROAD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First HARRY Middle MILTON Last POWELL
4. DATE OF DEATH: Month 1 Day 19 Year 1962
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH: 12/21/1897
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINIST
10b. KIND OF BUSINESS OR INDUSTRY: MANUFACTURING
11. BIRTHPLACE (County & State, or foreign country): CARROLL CO.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: CHARLES UPTON POWELL
14. MOTHER'S MAIDEN NAME: ALVERTA MAE FOWLER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 212-18-2046
17. INFORMANT: MRS. JOSEPH E BYERS Address: RD #4 WESTMINSTER, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) | BRONCHO PNEUMONIA | 4 DAYS |
| DUE TO (b) | CARCINOMATOSIS PRIMARY UNKNOWN | 10 MO. |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from NOV 19 61 to JAN 19 62 that (I) (we) last saw the deceased alive on JAN 16 19 62 and that death occured at 7:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Daniel I Welliver M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 1/14/62
22c. PHYSICIAN'S NAME (Type): DANIEL I WELLIVER
22d. ADDRESS: 19 RIDGE RD WESTMINSTER MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/21/62
23c. NAME OF CEMETERY OR CREMATORY: MEADOW BRANCH CEM.
23d. LOCATION (City, town or county) (State): WESTMINSTER, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: James L. Saffell Jr.
ADDRESS: 25 E. MAIN ST. WESTMINSTER, MD.

25a. REC'D BY REGISTRAR DATE: JAN 24 '62
25b. REGISTRAR'S SIGNATURE: Luther S. Kramer

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00460 Item 9 Fill Gds 7/10/62 jwk 001457

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Carroll
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN this MARYLAND: 18 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookeville
   d. STREET ADDRESS: R.F.D. 1, Box 52
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Herman; Middle: Henry; Last: PRIEBE

4. **DATE OF DEATH**: Month: 1; Day: 6; Year: 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 1-7-85

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custom work for farmers

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herman H. Priebe

14. MOTHER'S MAIDEN NAME: Bertha Feiblekorn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield State Hosp. Records — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease. — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4-20.6

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [XX]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-20-61 19 to 1-6-62 19, that (I) (we) last saw the deceased alive on 1-6-62 19, and that death occured at 7:30 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. M.D. ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 1-6-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-9-62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel

23d. LOCATION (City, town or county) (State): Sunshine, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber

ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR DATE: JAN 9 '62

25b. REGISTRAR'S SIGNATURE: Esther L. Mears

VR A15 4
15M 7 62

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3 & 13 Film G305 1/12/62 iwk

## CERTIFICATE OF DEATH

90461 Reg. Dist. No. 00458

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural New Windsor
c. LENGTH OF STAY IN 1b: 6 Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: At Marston

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural New Windsor
d. STREET ADDRESS: At Marston
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First CEPHAS Middle A. Last RAINS Raines

4. DATE OF DEATH: Month January Day 9, Year 1962

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: May 20, 1887
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter ( Retired )
10b KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Cephas S. RAINS Raines
14. MOTHER'S MAIDEN NAME: Maggie F. Burns

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 215-14-2688
INFORMANT Address: Mrs. Ethel Rains, Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 8 days

Conditions if any which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardio-Vascular Disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 11/2/62, 19____, to 11/9/62 19___, that I last saw the deceased alive on 11/9/62, 19_____, and that death occurred at 7:45 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: M.E. Robertson M.D. ADDRESS (Street, city or town, state): New Windsor md DATE SIGNED: 11/9/62

PHYSICIAN'S NAME (Type): M. E. Robertson, M. D. New Windsor, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 12, 1962
22c NAME OF CEMETERY OR CREMATORY: Marvin Chapel
22d. LOCATION (City, town, or county) (State): Frederick Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz, Winfield, Maryland
24a. REC'D BY REGISTRAR DATE: JAN 10 '62
24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00462 — 00454

1. **PLACE OF DEATH**
a. COUNTY: CARROLL COUNTY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER RURAL
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL OR INST.TUTION (If not in hospital, give street address): RT #7 WESTMINSTER, MD.

2. **USUAL RESIDENCE** (Where deceased l ved, If institution: Residence before adm ssion)
a. STATE: MARYLAND. b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town): WESTMINSTER (RURAL)
d. STREET ADDRESS: RT #7. WESTMINSTER
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: ELLA — Middle: LOUISE — Last: RAY

4. DATE OF DEATH: Month: JAN — Day: 15, — Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARR ED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF B RTH: JAN. 6 A '62

9. AGE (In years last birthdey) yrs.: IF UNDER 1 YEAR Months: 9 Days: Hours: IF UNDER 24 HRS. M.n.:

10a. USUAL OCCUPATION (Give kind of work done dur ng most of work ng life, even if retired): —

10b. KIND OF BUS NESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): CARROLL COUNTY

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: JOHN HARVEY RAY

14. MOTHER'S MAIDEN NAME: LULA MAE BALL

15. WAS DECEASED EVER IN U S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service):

16. SOCIAL SECURITY NO: —

17. INFORMANT: FATHER - Address: JOHN HARVEY RAY RT#7 WESTMINSTER, MD

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): 753.1 MICROCEPHALY — INTERVAL BETWEEN ONSET AND DEATH: 9 DAYS

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART I OTHER S.GN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE COND.TION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW NJURY OCCURED. (Enter nature of njury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Yeer 19 —

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) (this hospita ) attended the deceased from 1/6, 1962 to 1/15, 1962, that (I) (we) last saw the deceased alive on 1/11, 1962, and that death occured 8:45 A.M., from the causes and on the date stated above.

22a. S GNATURE: William L. Stewart, M.D.

ATTENDING PHYS. [X] MED. D RECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 1/15/62

22c. PHYSICIAN'S NAME (Type): WILLIAM L. STEWART

22d. ADDRESS: 19 RIDGE RD. WESTMINSTER, MD.

23a. BURIAL CREMATION REMOVAL (Specify): BURIAL

23b. DATE THEREOF: JAN 16TH, 1962

23c. NAME OF CEMETERY OR CREMATORY: THOMPSON'S CEMETERY

23d. LOCATION (City, town or county) (State): HONAKER, VA.

24. FUNERAL DIRECTOR'S SIGNATURE: James G. Saffell Jr. — ADDRESS - Westminster, Md.

25a. REC'D BY REGISTRAR DATE: JAN 16 '62

25b. REGISTRAR'S SIGNATURE: Guy D. Hines

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00463 00460

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FINKSBURG
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If inst tut on: Residence before adm ssion)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and g ve neerast town): Hampstead
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bill — Middle: Milson — Last: T

4. DATE OF DEATH: Month: JAN — Day: 8 — Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-19-1906

9. AGE (In years last birthday): 33 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Gasoline

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W Rill

14. MOTHER'S MAIDEN NAME: Laura Barber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service): No

16. SOCIAL SECURITY NO.: 215-07-4802

17. INFORMANT: Address: Mrs Roberta Rill, Hampstead Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 1-20 ✓ — CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: MIN
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county): CARROLL

DATE SIGNED: 1-8-62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-11-1962

22c. NAME OF CEMETERY OR CREMATORY: Wesley Meth.

22d. LOCATION (City, town, or country) (State): Carroll Co Maryland

23. FUNERAL DIRECTOR: Tipton-Eline — ADDRESS: Hampstead Md

24a. REC'D BY REGISTRAR — DATE: JAN 10 '62

24b. REGISTRAR'S SIGNATURE: [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00464

## CERTIFICATE OF DEATH

M461

1. **PLACE OF DEATH**
   a. COUNTY: Carroll
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 11 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 11
   d. STREET ADDRESS: 3937 Roland Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katie; Middle: Priscilla; Last: Roloson

4. DATE OF DEATH: Month: January; Day: 19; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 14, 1876

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Myers

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: - -

17. INFORMANT Address: Springfield Hospital Records

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Acute renal inssuficiency | days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b) | Chronic nephro-sclerosis | year s |
| DUE TO (c) | Generalized arteriosclerosis and Diabetis | years |

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with senile brain disease with psychosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-8-62, 19 62, to 1-19-62, 19 62 that (I) (we) last saw the deceased alive on 1-19-62, and that death occured at 4.30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-19-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/22/62

23c. NAME OF CEMETERY OR CREMATORY: LOUDON PARK

23d. LOCATION (City, town or county) (State): FREDRICK RD, MD

24 FUNERAL DIRECTOR'S SIGNATURE: Austin E. Dorsey

ADDRESS: 3818 Roland Ave

25a. REC'D BY REGISTRAR DATE: JAN 22 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00465

## CERTIFICATE OF DEATH

011462

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 18
d. STREET ADDRESS: 2717 Greenmount Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mollie; Middle: Elizabeth; Last: Romoser

4. DATE OF DEATH: Month: January; Day: 18; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1881

9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR, Months, Days. IF UNDER 24 HRS., Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales girl

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William A. Edwards

14. MOTHER'S MAIDEN NAME: Nellie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service): No -

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT: Springfield State Hospital — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: C.B.S. associated with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-28- 1961 to 1-18- 1962, that (I) (we) last saw the deceased alive on 1-18-1962, and that death occured at 1:40 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-18-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/20/62

23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEM

23d. LOCATION (City, town or county) (State): BALTO

24. FUNERAL DIRECTOR'S SIGNATURE: NIEMEYER & SON

ADDRESS: 501 E. 22ND ST

25a. REC'D BY REGISTRAR DATE: JAN 22 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

66466 — 11463

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Golden Age Guest Home

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY:
   c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 829 Hillman Court
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Lula — Middle: F. — Last: Russell

4. **DATE OF DEATH**: Month: Jan. — Day: 28, — Year: 1962

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 12, 1892

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired cashier

10b. KIND OF BUSINESS OR INDUSTRY: Brager Eisenberg's

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Pullen

14. MOTHER'S MAIDEN NAME: Mary Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO. (If yes give wer or dates of service): none

17. INFORMANT: Carl L. Zepp 3705 McTavish Ave. #29 — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Cardiac failure

DUE TO (b): Myocardial

DUE TO (c): Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — 4 4 3 X

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 1st, 1959 to Jan 28th 1962, that (I) (we) last saw the deceased alive on Jan 28 1962 and that death occured at 6 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Morrell N Martin — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): MORRELL N MARTIN

22d. ADDRESS: Sykesville Md

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/31/62

23c. NAME OF CEMETERY OR CREMATORY: Western Cemetery

23d. LOCATION (City, town or county): Baltimore, Maryland (State): Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Howard H. Hubbard 4107 Wilkens Avenue #29

25a. REC'D BY REGISTRAR DATE: JAN 31 '62

25b. REGISTRAR'S SIGNATURE: Esther L. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00467

## CERTIFICATE OF DEATH

Reg. Dist. No. 00343

1. PLACE OF DEATH
a. COUNTY: Carroll Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 50yrs.+
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 109 John St

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 West minster
d. STREET ADDRESS: 109 John St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EMMA Middle CATHERINE Last SCHAEFER

4. DATE OF DEATH: Month JAN. Day 30 Year 1962

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 24 1870
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home - wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fred. Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jeremiah Flohr
14. MOTHER'S MAIDEN NAME: Catherine Furor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
INFORMANT: Elmer F. Schaefer, Westminster, Md
Address:

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
DUE TO (b): Arterio-Sclerotic Coronary Disease — 5 years
DUE TO (c):

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.: none 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 30, 1936, to 1-30, 1962 that I last saw the deceased alive on Jan. 29th, 1962 and that death occurred at 3A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. H. Billingslea M.D.
ADDRESS (Street, city or town, state): Westminster, Md.
DATE SIGNED: 1-30-62
PHYSICIAN'S NAME (Type): C. H. Billingslea

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/1/62
22c. NAME OF CEMETERY OR CREMATORY: Fridens Cemetery
22d. LOCATION (City, town, or county) (State): Rural Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr., Westminster, Md.
ADDRESS:
24a. REC'D BY REGISTRAR DATE: FEB 1 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00468 00464

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville
   c. LENGTH OF STAY IN 1b: 5mo 10d.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   d. STREET ADDRESS: 169 Lincoln Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Allan — Middle: Monroe — Last: Sellers

4. **DATE OF DEATH**: Month: 1 — Day: 5 — Year: 19 62

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/16/78

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Sellers

14. MOTHER'S MAIDEN NAME: Elizabeth Richards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): unknown

16. SOCIAL SECURITY NO.: 212-05-0861

17. INFORMANT — Address: Hospital Records

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Septicaemia
- DUE TO (b): Infected multiple wounds
- DUE TO (c):

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: days — weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/25/61, 19 , to 1/5, 19.62, that (I) (we) last saw the deceased alive on 1/5, 19.62, and that death occured at 9a.M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 1/5/62

22c. PHYSICIAN'S NAME (Type): Yasuo Takahashi, M.D.

22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1/8/62 — 23c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery — 23d. LOCATION (City, town or county): Westminster — (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. C. Myers, Jr. — ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR DATE: JAN 8 '62 — 25b. REGISTRAR'S SIGNATURE: [signature]

VR A1S 41
15M 7 61

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00469 — Reg. Dist. No. 011465

1 PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 90 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 143 Penna Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 143 Penna Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES — Middle LEONARD — Last SHAEFFER

4. DATE OF DEATH: Month JAN. — Day 25 — Year 1962

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 19 1871
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): plumber
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Westminster
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. Shaeffer
14. MOTHER'S MAIDEN NAME: Sarah Ansler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
INFORMANT: Mrs Raymond E. Snyder, Same — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: about 6 mos.
DUE TO (b): Arterio Sclerosis — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Extensive basal cell epithelioma — 10 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Senile Decay + Infirmities.
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): —
20c. TIME OF INJURY Hour a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from about Jan. 1st, 1942, to 1-25, 1962 that I last saw the deceased alive on 1-23, 1962, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. H. Billingslea M.D. — ADDRESS (Street, city or town, state): Westminster, Md. — DATE SIGNED: 1-25-62

PHYSICIAN'S NAME (Type): C. H. Billingslea

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/27/62
22c. NAME OF CEMETERY OR CREMATORY: Pleasant View
22d. LOCATION (City, town, or county) (State): Rural Westminster, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers, Jr. — ADDRESS: Westminster Md.
24a. REC'D BY REGISTRAR DATE: JAN 30 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR AT... may be retained ... TO FUNERAL DIRE...

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de... Page 4 ... tal or attending physician. After this certificate has been signed by the attending physician and completely filled in by th... eral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

90470 — 00466

**1. PLACE OF DEATH**
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pleasant Valley
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hiner Convelscent Home

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Taneytown
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Catherine; Middle: Lydia; Last: Shriner

**4. DATE OF DEATH**: Month: January; Day: 19; Year: 1962

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: Nov. 17, 1875

**9. AGE** (In years last birthday): 86 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House work

**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home

**11. BIRTHPLACE** (County & State or foreign country): Carroll County, Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U? S. A.

**13. FATHER'S NAME**: Jacob S. Haifley

**14. MOTHER'S MAIDEN NAME**: Lydia Stonesifer

**15. WAS DECEASED EVER IN U.S ARMED FORCES?** (Yes, no, or unkown) (If yes give were or dates of service): No

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT** Address: Mr. H. Lee Haifley, Sr., Taneytown, Maryland

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Myocerditis + Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO (b): Arteriosclerotic Heart Disease — 10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Generalized Arteriosclerosis

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☑

**MEDICAL CERTIFICATION**

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from June 5, 1961 to Jan 1 a., 19.., 1962, that (I) (~~We~~) last saw the deceased alive on Jan. 19 1962, and that death occured at 10 P.M. from the causes and on the date stated above

22a. SIGNATURE: R. S. McVaugh — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/20/62

22c. PHYSICIAN'S NAME (Type): R. S. McVaugh

22d. ADDRESS: Taneytown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan. 22, 1962

23c. NAME OF CEMETERY OR CREMATORY: Baust Cemetery

23d. LOCATION (City, town or county) (State): Tyrone, Carroll, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John H Stiles

C.O. Fuss & Son

ADDRESS: Taneytown, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 23 '62

25b. REGISTRAR'S SIGNATURE: Clarence L. Travis

**TO HOSPITAL OR ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

20471 — 100467

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 4 mos./7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore #2
d. STREET ADDRESS: 1321 N. Calvert St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ray — Middle: Spangler — Last: SIMONS

4. DATE OF DEATH: Month: January — Day: 28, — Year: 1962

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-29-1889

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Simmons

14. MOTHER'S MAIDEN NAME: Stella Spangler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT: Springfield State Hosp. Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b): Congestive heart failure — months
DUE TO (c): A.S.C.V.D. — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Manic depressive reaction, depressed type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/21/61 ..., 19 , to 1/28/62 , 19 ..., that (I) (we) last saw the deceased alive on 1/28/62 ..., 19 ..., and that death occured at 2:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D. — ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 1/28/62

22c. PHYSICIAN'S NAME (Type): Agustin del Carpo, M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1/31/1962 — 23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery — 23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: H.W.Jenkins & Sons Co. 4905 York Rd. Balto.12, Md.

25a. REC'D BY REGISTRAR — DATE: JAN 31 '62 — 25b. REGISTRAR'S SIGNATURE: Catherine L. Howe

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7 61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

20472 Item 9-11-m 6502 1/12/62 iwk (11469)

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville,
c. LENGTH OF STAY IN 1b: 1yr7mos26dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Middletown,
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: May — Last: Stillwell

4. DATE OF DEATH: Month: January — Day: 7 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 14, 1880

9. AGE (In years last birthday): 81 82 yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lansing Bowings

14. MOTHER'S MAIDEN NAME: Lucinda Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Septicemia | 5 days |
| DUE TO (b) | Pulmonary abscess | 5 days |
| DUE TO (c) | Suppurative parotitis | 7-10 days |
| | Emaciation and dehydration | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 527X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: C.B.S. associated with cerebral arteriosclerosis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-31-60, 19..., to 1-7-, 1962 that (I) (we) last saw the deceased alive on 1-7- 1962, and that death occured at 8:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-7-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-10-62

23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery

23d. LOCATION (City, town or county) (State): Frederick, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: M. R. Etchison & Son, Frederick, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 10 '62

25b. REGISTRAR'S SIGNATURE: Clinton L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

30473

# CERTIFICATE OF DEATH

Reg. Dist. No. 011470

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg

c. LENGTH OF STAY IN 1b: 9 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Finksburg

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIE Middle CATHERINE Last STOVER

4. DATE OF DEATH: Month January Day 2 Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 10, 1878

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Upton, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Hancock

14. MOTHER'S MAIDEN NAME: Sarah Lilly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Goldie Stover, Finksburg, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arteriosclerotic C-V Disease — 2 yrs.

DUE TO

(c) Diabetes — 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Bronchitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): none

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year: none 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-9-59, 19____, to 1-2-62, 19____, that I last saw the deceased alive on 1-2-62, 19____, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: X D. Caples M.D. — ADDRESS (Street, city or town, state): 6 Hanover Rd. — DATE SIGNED: 1-2-62

PHYSICIAN'S NAME (Type): D. D. Caples, M. D. — Reisterstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/5/62

22c. NAME OF CEMETERY OR CREMATORY: Green Hill

22d. LOCATION (City, town, or county) (State): Waynesboro, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Kelly G. Grove — ADDRESS: Waynesboro, Penna.

24a. REC'D BY REGISTRAR DATE: JAN 4 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: No burial or removal from this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00474

## CERTIFICATE OF DEATH

00471

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 contains instructions obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN this MARYLAND: 1yr.3mos.25dys
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 5
d. STREET ADDRESS: 2829 E. Madison Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alwina; Middle: ; Last: Sullens

4. DATE OF DEATH: Month: January; Day: 29; Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 17, 1879

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: - UNKNOWN

14. MOTHER'S MAIDEN NAME: - UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS HENRY SCHULTZ Address: 200 Huron Rd.
Springfield Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Ataxia due to gastric cancer. — INTERVAL BETWEEN ONSET AND DEATH: 6 to 8 months

42 2-1

DUE TO (b): Arteriosclerotic C.V.D. — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.: C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10-4-, 1960, to 1-29-, 19 62 that (I) (we) last saw the deceased alive on 1-29- 19 62, and that death occured at 9:50 P.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-29-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/2/62

23c. NAME OF CEMETERY OR CREMATORY: BALTIMORE CEMETERY

23d. LOCATION (City, town or county) (State): BALTIMORE MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HENRY SANDER & SONS INC. BALTO. MD.

25a. REC'D BY REGISTRAR DATE FEB 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kline

VR AIS (4)
15M 7.61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

20475

## CERTIFICATE OF DEATH

001472

Item 2 Film-G505 1/24/62 awk

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland Penna. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): None given Lebanon
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Henry Middle: William Last: Tschudy

4. **DATE OF DEATH**: Month: 1 Day: 13 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-25-1875

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cigar maker

10b. KIND OF BUSINESS OR INDUSTRY: Owned grocery store

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Tschudy

14. MOTHER'S MAIDEN NAME: Priscilla Eberly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Springfield State Hosp. Records — Address

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intestinal Infarction
DUE TO
4504
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Thrombosis of Mesenteric Artery
(c): Advanced generalized atheromatosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a:

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-27- , 1961 to 1-13 , 1962, that (I) (we) last saw the deceased alive on 1-13 , 19 62, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒x

22b. DATE SIGNED: 1-14-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hosp. Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-17-62

23c. NAME OF CEMETERY OR CREMATORY: United Zion

23d. LOCATION (City, town or county) (State): Campbelltown, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Luther H Haught

ADDRESS: Sykesville, Md

25a. REC'D BY REGISTRAR DATE: JAN 22 '62

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00476 — 00473

1. PLACE OF DEATH
a. COUNTY: CARROLL CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 53 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 21 CHURCH STREET

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER, MD.
d. STREET ADDRESS: 21 CHURCH STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES — Middle VERNON — Last TURFLE

4. DATE OF DEATH: Month JAN. — Day 21 — Year 1962

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 1/21/1867 — 9. AGE (In years last birthday): 95 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10b. KIND OF BUSINESS OR INDUSTRY: HOUSE PAINTER
11. BIRTHPLACE (County & State, or foreign country): CARROLL COUNTY
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: THOMAS TURFLE
14. MOTHER'S MAIDEN NAME: MARGARET MILLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
16. SOCIAL SECURITY NO (If yes give war or dates of service): NO — 216-14-6749
17. INFORMANT: MRS MARK NULL — Address: 19 CHURCH ST WESTMINSTER, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute dilatation of heart — INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO (b): chronic myocarditis — 5 years
DUE TO (c): arterio-sclerosis — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 2 2.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19 —
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 10 ..., 1962 to 1-21 ..., 1962, that (I) (~~we~~) last saw the deceased alive on 1-20 ..., 1962 and that death occured at 6 A.M, from the causes and on the date stated above.

22a. SIGNATURE: C. J. Billingslea M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 1-22-62
22c. PHYSICIAN'S NAME (Type): C. J. Billingslea
22d. ADDRESS: Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/24/62
23c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEM.
23d. LOCATION (City, town or county) (State): WESTMINSTER, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: James G. Saffell Jr.
ADDRESS: WESTMINSTER, MD.
25a. REC'D BY REG STRAR: DATE JAN 23 '62
25b. REGISTRAR'S SIGNATURE: Lucy L. Hann

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00477

## CERTIFICATE OF DEATH

00474

**1. PLACE OF DEATH**
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Union Mills
c. LENGTH OF STAY: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Meadow View Home

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reisterstown
d. STREET ADDRESS: 46 Chatsworth Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: George Middle: Andrew Last: Uhler

**4. DATE OF DEATH**: Month: January Day: 21 Year: 1962

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: Dec. 10, 1878

**9. AGE** (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired Mail Carrier

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: George W. Uhler

**14. MOTHER'S MAIDEN NAME**: Margaret Berryman

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service): No

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT** Address: Mrs. Jessie M. Uhler, Reisterstown, Md.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocarditis - Chronic Decompensated

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): General arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs / years / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Diabetes

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 1-1-1962 to 1-21-62, that (I) (~~saw~~) last saw the deceased alive on 1-20-1962, and that death occured at 2:40 P.M., from the causes and on the date stated above.

**22a. SIGNATURE**: James G. Saffell M.D.

**22b. DATE SIGNED**: 1-21-62

**22c. PHYSICIAN'S NAME** (Type): James G. Saffell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22d. ADDRESS**: Reisterstown, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: Jan. 24, 1962

**23c. NAME OF CEMETERY OR CREMATORY**: All Saints

**23d. LOCATION** (City, town or county) (State): Reisterstown, Md.

**24 FUNERAL DIRECTOR'S SIGNATURE**: J. T. Cline Sons

**ADDRESS**: Reisterstown, Md.

**25a. REC'D BY REGISTRAR** DATE JAN 23 '62

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Norris

**TO HOSPITAL & ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00478

## CERTIFICATE OF DEATH

111475

**1. PLACE OF DEATH**
a. COUNTY: CARROLL CO. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WINFIELD, MD.
c. LENGTH OF STAY IN 1b: 1 WEEK
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): GOLDEN AGE GUEST HOME

**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER, MD.
d. STREET ADDRESS: 239½ E. MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: CARRIE — Middle: VIRGINIA — Last: WAGNER

**4. DATE OF DEATH**: Month: 1 — Day: 20 — Year: 1962

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: AUG 5 1872

**9. AGE** (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY**: —

**11. BIRTHPLACE** (County & State or foreign country): CARROLL CO.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: JOHN THOMAS HAINES

**14. MOTHER'S MAIDEN NAME**: MARY JANE FRIZZELL

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service):

**16. SOCIAL SECURITY NO.**: —

**17. INFORMANT**: MRS JOHN WAGNER — Address: 289 E. MAIN ST.

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
DUE TO (b): Gen'l. Arter. Sclerosis — 10 yrs
DUE TO (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): no

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**MEDICAL CERTIFICATION**

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 1st 1962 to Jan 19, 1962, that (I) (we) last saw the deceased alive on Jan 18 1962 and that death occured 4:25 P.M., from the causes and on the date stated above.

22a. (SIGNATURE) Murrell M. Martin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): MURRELL MARTIN

22d. ADDRESS: Sykesville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/23/62

23c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEM.

23d. LOCATION (City, town or county) (State): WESTMINSTER MD.

24 FUNERAL DIRECTOR'S SIGNATURE: James D. Baffell — ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR DATE: JAN 22 '62

25b. REGISTRAR'S SIGNATURE: Orville L. Haines

**TO HOSPITAL NG PHYSICIAN:** The law requires that the death certificate be executed within 24 after death. Page 4 by the hospital or attending physician.

**TO FUNERAL** er this certificate has been signed by the attending physician and completely filled the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00479 Item 23a Film G30 1/19/62 mh 011476

**1. PLACE OF DEATH**
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN: MARYLAND 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Henryton State Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institutions: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marbury
d. STREET ADDRESS: C R 2
IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: ; Last: Washington
4. DATE OF DEATH: Month: January; Day: 9; Year: 1962
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-26-1872
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Government
10b. KIND OF BUSINESS OR INDUSTRY: Government
11. BIRTHPLACE (County & State or foreign country): Port Tobacco, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Washington
14. MOTHER'S MAIDEN NAME: Mamie Thomas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): ??
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Doris Farmer
Address: Indianhead, Md. - 102 Bertha Circle

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Sudden heart death
450.0
DUE TO (b): General arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Minimal pulmonary tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
??

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from January 3 1962, to January 9, 1962, that (I) (we) last saw the deceased alive on January 9 19 62, and that death occured at 5:30 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 1-9-62
22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M. D.
22d. ADDRESS: Henryton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 13-Jan 62
23c. NAME OF CEMETERY OR CREMATORY: Church cemetery
23d. LOCATION (City, town or county): Hill Top (State): Md

24. FUNERAL DIRECTOR'S SIGNATURE: John T. Rhine Co
ADDRESS: 3015-12th St. N.E.
25a. REC'D BY REGISTRAR DATE: JAN 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 should be signed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

90480 — 00427

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN this place: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Henryton State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: 600 Preston Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Watson

4. DATE OF DEATH: Month: Jan. — Day: 14, — Year: 1962

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-3-1898

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Curtis Waters

14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mary Watson - Patient — Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

(a) Meningitis — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Far advanced pulmonary tuberculosis

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — a.m. p.m. — Month, Day, Year: — 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 20, 1961 to Jan. 14, 1962 that (I) (we) last saw the deceased alive on Jan. 14, 1962, and that death occured at 11:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. Edgars M. Maculans, Supt. — 22d. ADDRESS: Henryton State Hosp., Henryton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1/18/62 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem. — 23d. LOCATION (City, town or county): Brooklyn, (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE: C. O. Wilson — ADDRESS: 844 1000 Bronthley Ave

25a. REC'D BY REGISTRAR DATE: JAN 19 '62 — 25b. REGISTRAR'S SIGNATURE: [illegible] S. Kinna

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

## CERTIFICATE OF DEATH

00491 — 001478

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 to be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS 41
15M 7 61

1. **PLACE OF DEATH**
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN MARYLAND: 1yr.19days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Pleasant
d. STREET ADDRESS: R#1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Daniel; Middle: Webster; Last: Wolfe

4. DATE OF DEATH: Month: January; Day: 16; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: February 26, 1880

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm work

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel Wolfe

14. MOTHER'S MAIDEN NAME: Rebecca ~~Gaver~~ Gaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records.
Address:

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, right lung.
DUE TO (b): Arteriosclerotic cardiovascular disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH
Days.
Years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)!

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December 27, 1960 to January 16, 1962, that (I) (we) last saw the deceased alive on January 16, 1962, and that death occured at 9:50PM from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: 1/17/62

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-20-1962
23c. NAME OF CEMETERY OR CREMATORY: Beaver Dam Cemetery
23d. LOCATION (City, town or county) (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Hunt & Wilson Jr. Frederick, Md.
ADDRESS:

25a. REC'D BY REGISTRAR DATE: JAN 19 '62
25b. REGISTRAR'S SIGNATURE:

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00482

## CERTIFICATE OF DEATH

Reg. Dist. No. 00479

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RURAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
d. STREET ADDRESS: RURAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUFUS Middle CLARENCE Last YINGLING

4. DATE OF DEATH: Month JAN Day 14 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 28 - 1900

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MECHANIC

10b. KIND OF BUSINESS OR INDUSTRY: FARM MACH.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: J. HARRY YINGLING

14. MOTHER'S MAIDEN NAME: S. EDNA KOONTZ

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-01-8723

INFORMANT: J. FENTON YINGLING Address: UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure
DUE TO (b): arteriosclerotic cardio-vascular disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.

INTERVAL BETWEEN ONSET AND DEATH: 1 month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/23/61, 19____, to 1/14/62 19___, that I last saw the deceased alive on 1/11/62, 19____, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M. E. Robertson M.D. ADDRESS (Street, city or town, state): New Windsor, Md, DATE SIGNED: 1/14/62

PHYSICIAN'S NAME (Type): M. E. ROBERTSON NEW WINDSOR MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JAN 16-62

22c. NAME OF CEMETERY OR CREMATORY: WINTERS MEM. CARROLL COUNTY

22d. LOCATION (City, town, or county) (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: D. A. Hartlerstown ADDRESS: NEW WINDSOR MD

24a. REC'D BY REGISTRAR DATE: JAN 16 '62

24b. REGISTRAR'S SIGNATURE: Clinton S. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00483 — 00480

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Thurmont
d. STREET ADDRESS: 17 W. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha; Middle: Castle; Last: Zimmerman

4. DATE OF DEATH: Month: January; Day: 24; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 19, 1867

9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Land Lady

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: W. W. Zimmerman

14. MOTHER'S MAIDEN NAME: Cordelia Castle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give wer or dates of service): –

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10-20 years
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. due to generalized arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-18-62 19..., to 1-24- 19 62 that (I) (we) last saw the deceased alive on 1-24- 1962, and that death occured at 4:15 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 1-24-62

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 1-27-62

23c. NAME OF CEMETERY OR CREMATORY: United Brethern Cem.

23d. LOCATION (City, town or county) (State): Thurmont, Md. Fred. Co.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Raymond L. Creager & Son, Thurmont Md.

Raymond L Creager

25a. REC'D BY REGISTRAR — DATE: JAN 26 '62

25b. REGISTRAR'S SIGNATURE: Carlton L. Kinnie

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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